

The Pilot Process: Case Study on Piloting Complex Health Reforms in Kyrgyzstan

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Partners for Health Reformplus is USAID's flagship project for health policy and health system strengthening in developing and transitional countries. The five-year project (2000-2005) builds on the predecessor Partnerships for Health Reform Project, continuing PHR's focus on health policy, financing, and organization, with new emphasis on community participation, infectious disease surveillance, and information systems that support the management and delivery of appropriate health services. PHRplus will focus on the following results:

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- ▲ *Generation of new financing for health care, as well as more effective use of existing funds.*
- ▲ *Design and implementation of health information systems for disease surveillance.*
- ▲ *Delivery of quality services by health workers.*
- ▲ *Availability and appropriate use of health commodities.*

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Acronyms

FGP	Family Group Practice
FMTC	Family Medicine Training Center
HFS	Health Financing and Sustainability Project
HIF	Health Insurance Fund
JWG	Joint Working Group
MHI	Mandatory Health Insurance
MHIF	Mandatory Health Insurance Fund
MOH	Ministry of Health
OHD	Oblast Health Department
ODA	Organization for Development Assistance
USAID	U.S. Agency for International Development
WHO	World Health Organization

Foreword

The case study is meant to be descriptive of the health reform pilot processes in Kyrgyzstan and is not intended as a more rigorous evaluation of the pilot. This case study is funded by USAID under the Partners for Health Reform *plus* (PHR *plus* Project), being implemented by Abt Associates. Abt Associates Inc. also implements the USAID-funded ZdravPlus Project in Central Asia. ZdravPlus was substantially involved in providing technical assistance to the design and implementation of the health reform pilot in Issyk-Kul oblast. The author of this case study worked on the ZdravPlus Project from May 1999 to May 2002 and now works in Abt Associates' headquarters in Bethesda, MD to provide management and technical support to a number of projects in the Europe and Eurasia region. The author has attempted to avoid bias.

In addition to referencing published and gray literature, this case study relies on personal interviews conducted in April 2003 with Dr. Tilek Meimanaliev, Deputy Minister of Health; Ainura Ibraimova, General Director, Mandatory Health Insurance Fund; Joe Kutzin, Regional Advisor, Health Systems Financing, WHO/EURO; Sheila O'Dougherty, Regional Director, USAID-funded ZdravPlus Project; and Cheryl Cashin, Associate Professor, Boston University (formerly with Abt Associates as a regional economist on the ZdravPlus Project).

The author would like to thank Sara Bennett and Sheila O'Dougherty for their review of the case study and their excellent comments.

Executive Summary

The concept of piloting has been effectively used in implementing health sector reform throughout the former Soviet Union. One of the first pilots in Central Asia, established in 1994 in Issyk-Kul *oblast* (province or state) in Kyrgyzstan, continues to provide valuable information on the process of piloting complex health reforms. The primary objective of the pilot in Issyk-Kul oblast was to develop or refine a health system design, specifically to demonstrate the feasibility of a mandatory health insurance scheme.

Other objectives included demonstrating specific reform designs to provide information and evidence to national stakeholders over time and to simultaneously build capacity for further implementation.

This case study describes the pilot process in Kyrgyzstan, including factors involved in the development of the pilot approach, as well as dimensions and outcomes of the pilot. The study aims to:

- ▲ Contribute to greater appreciation for the steps involved in designing and implementing a regional pilot to test complex health reform;
- ▲ Describe how a pilot approach can continuously inform national policy and decision making; and
- ▲ Determine the factors that supported implementation, roll-out, and scale-up of pilot activities.

Despite the absence of a rigorous comprehensive evaluation, the health reform pilot in Issyk-Kul oblast can be considered a success. The pilot resulted in the reorganization of the oblast health care delivery system, and opened the way for improvements in efficiency and quality of care. Positive results obtained in Issyk-Kul oblast led to expansion of the reform model to additional oblasts, institutionalization of health reform at the national level, and development of a productive collaboration among donors. Implementation of the model built capacity to implement at oblast and national levels and familiarized stakeholders with the benefits of piloting.

The pilot project in Issyk-Kul and health reform efforts more generally were successful for a number of reasons. The health reform model was appropriate to the Kyrgyz setting, the political context was conducive to reform and experimentation, and a consistent, yet flexible vision was developed to guide reform efforts. A step-by-step operational approach and well-defined processes (pilots, joint working groups) to plan, discuss, problem solve, and evaluate health reform implementation enabled counterparts to learn by doing, use evidence to inform decisions, and institutionalize health sector decision making. Consistent and knowledgeable counterparts (turned health reform champions) were critically important to success, as were high quality technical assistance and effective donor collaboration. The initial pilot, subsequent roll-out, and national institutionalization were made possible through committed local financing, health sector savings from

rationalization, two World Bank health sector loans, and other donor financing for technical assistance.

While each of the factors mentioned above contributed to the success of the Issyk-Kul pilot, the dynamic interaction and iteration among the factors, coordinated by health champions and donors guided by a unified health reform vision, are responsible for the success of health reforms in Krygyzstan. The development of an effective dynamic process and experienced health reformers that allow and encourage sustainable health system improvements at both facility and system levels is the best legacy of the Issyk-Kul oblast pilot, and may be the true measure of its success.

1. Introduction

The purpose of this case study is to contribute to greater understanding of the *process* of piloting health reform initiatives as part of broader health system reform efforts. The USAID-funded Partners for Health Reform Plus (PHR*plus*) Project seeks to advance knowledge of health reforms and their impact, as well as to promote the exchange of information on critical health reform issues. A recent PHR*plus* review of experience on piloting health systems reform finds that the process of piloting complex health reform has been poorly documented, providing little guidance on when pilots may be an appropriate strategy to test new initiatives, or how pilots should be designed to meet the needs of different contexts (Bennett and Paterson, 2003). The review paper suggests a framework for improving the documentation of pilots, so that valuable information on pilot design and implementation might be collected and shared. This case study attempts to document the use of a pilot approach to implement health reform in Kyrgyzstan.

The concept of piloting has been used effectively in implementing health sector reform throughout the former Soviet Union. One of the first pilots in Central Asia, established in 1994 in Issyk-Kul *oblast* (province or state) in Kyrgyzstan (Figure 1), continues to provide valuable information on the process of piloting complex health reforms. The initial objective of the pilot was to provide the Kyrgyz government with a demonstration of a planned social health insurance model. During the design phase, the pilot quickly evolved into a broader health reform effort aimed at strengthening the primary care sector and downsizing an inefficient hospital sector to increase health system efficiency given existing resources, while simultaneously improving capacity at local and national levels to implement complex health reforms and introduce social health insurance.

Some early experiences and lessons learned from the Issyk-Kul pilot site fed into the concurrent development of a national health reform strategy (the MANAS Program). Over time, the development of the national strategy provided the top-down political support necessary for continuing, strengthening, and rolling out pilot activities in Issyk-Kul oblast. Even though the Issyk-Kul pilot project was never rigorously evaluated, the model that was tested was modified and refined based on implementation experience, rolled out to two additional oblasts after two years with assistance from a World Bank loan project, and eventually rolled out nationally. Experience and lessons learned in Issyk-Kul oblast with establishing a health insurance fund were used to establish a national health insurance fund in late 1996 and early 1997.

An achievement greater than national roll-out, however, may be the Ministry of Health's sophisticated appreciation for the role and use of pilots in developing and refining its policies. This appreciation can be attributed to a cadre of capable and progressive reform stakeholders at oblast and national levels, rigorous national-level capacity building by the World Health Organization (WHO), USAID, and other donors, and hands-on experience implementing and evaluating the Issyk-Kul pilot in stages. Recently, the Ministry of Health (MOH) has piloted continuous quality improvement processes, a single-payer financing model, an outpatient drug benefit for the insured, and new models of providing emergency care and ambulance services, with great success. In contrast to the Issyk-Kul oblast pilot, these pilots aimed to test and refine more specific and narrow health reform interventions and they have been more rigorously evaluated by the MOH and the Mandatory Health Insurance Fund

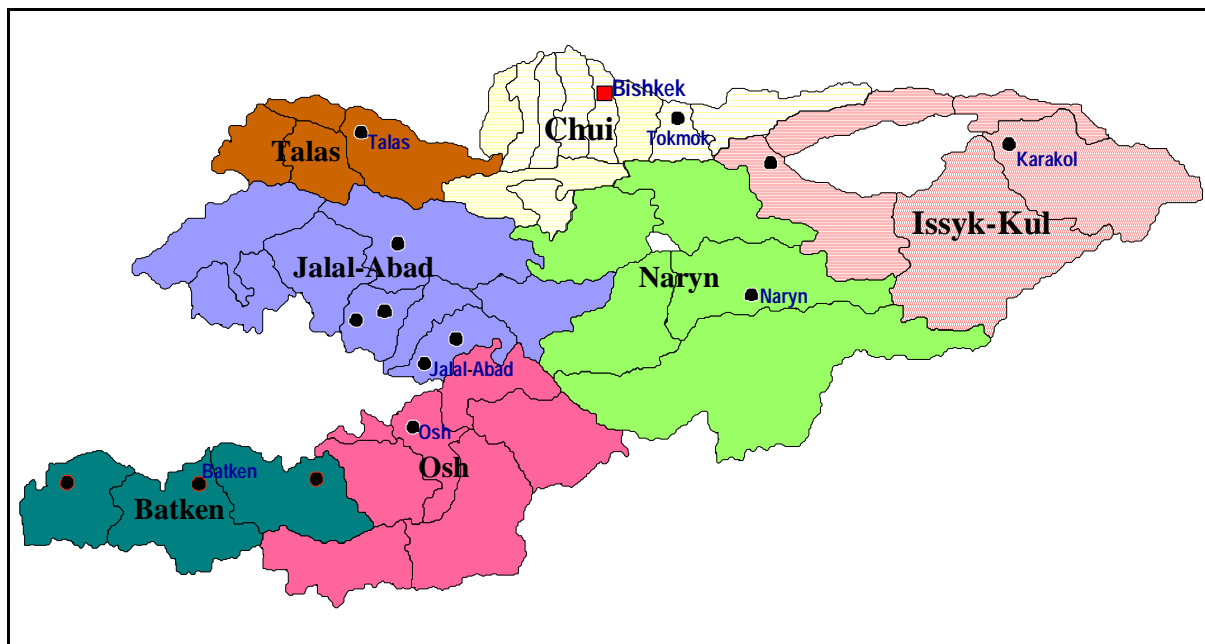
(MHIF), with support from WHO and other donors. Evaluation and implementation experience has led to refinement and phased implementation of a number of these “second generation” pilots.

This case study describes the pilot process in Kyrgyzstan, including factors involved in the development of the pilot approach, as well as dimensions and outcomes of the pilot. The study aims to:

- ▲ Contribute to greater appreciation for the steps involved in designing and implementing a regional pilot to test complex health reform;
- ▲ Describe how a pilot approach can continuously inform national policy and decision-making; and
- ▲ Determine the factors that supported implementation, roll-out, and scale-up of pilot activities.

The organization of this case study is largely chronological. Section 2 of the case study describes the pilot context in Kyrgyzstan in 1994-95, including the emergence of the pilot concept, how the pilot site was selected, and the principal actors involved in the pilot. Section 3 describes the design of the pilot – its objective, what was being piloted, and how it was to be monitored and evaluated. Section 4 provides an overview of the implementation process, and section 5 describes what monitoring and evaluation of the pilot actually took place. Section 6 provides outcomes of the pilot, Section 7 offers lessons learned, and Section 8 focuses on conclusions.

Figure 1: Regions of the Kyrgyz Republic



2. Pilot Context

2.1 Emergence of the Pilot Concept

The pilot concept emerged in early 1994 as the MOH was pressured by the government of Kyrgyzstan to begin implementing two laws that had been enacted in 1992. The Health Protection Act of the Kyrgyz Republic was passed on July 2, 1992, and outlined a program to:

- ▲ Develop a framework of health protection and define measures to ensure rights of citizens to sanitation and environmental health safety;
- ▲ Shift priorities toward health promotion and disease prevention and focus on primary and family-based care;
- ▲ Make changes in the form of health facility ownership; and
- ▲ Diversify and decentralize health revenue sources, mandating that health care financing be moved partially “off-budget” with revenues coming from special earmarked taxes and other services.

The Law of the Kyrgyz Republic on Medical Insurance was passed on July 3, 1992, and described the requirements for mandatory and voluntary medical insurance. The Law included a plan to create a health insurance fund in each oblast to be financed through a minimum 6 percent payroll contribution paid by employers, a per capita rate paid by the oblast government to cover non-working and exempt populations (including employees of public budget organizations), and funds transferred from the current 34.5 percent Social Insurance and Pension Fund payroll tax. A subsequent Cabinet of Ministers decree stated that implementation of the Medical Insurance Law would begin on January 1, 1995.

Poor macro-economic performance, a low tax revenue base, and a lack of technical capacity within the health sector delayed implementation of the 1992 health reform laws. But in early 1994, under pressure to meet the Cabinet of Minister’s deadline, the MOH hoped to develop a plan to demonstrate a transition from a government-financed, centrally planned health system to a more efficient system of health service organization and delivery of care, with mixed (public and private) financing. Realizing that such ambitious attempts to increase the efficiency of the health care system might have negative affects on access to and quality of care, the MOH planned an initial pilot project in a defined geographic area. The pilot project would implement the Medical Insurance Law in a comprehensive way but on a limited scale, and use experience and lessons learned to plan for national implementation (Langenbrunner et al., 1994).

USAID was simultaneously considering the concept of providing technical assistance in demonstration or pilot sites, as a way to provide rapid-response assistance on a wide range of health care financing and service delivery issues emerging throughout the former Soviet Union. USAID was fairly new to the region and “[t]here was considerable political pressure from the State Department

and internal pressure from USAID to start the process of health care reform through the Newly Independent States as soon as possible” (Laudato et al., 1997). One approach was for a potential USAID contractor to field teams that would analyze the local situation, propose site-specific programs to quickly test various models of reform and financing, and then replicate successful interventions more broadly in the medium to long-term.

MOH and USAID visions of piloting health reform in Kyrgyzstan converged in early 1994, when the government of Kyrgyzstan requested USAID to provide technical assistance in the area of health care financing reform, and more specifically to assist in evaluating the design of a health insurance demonstration to be implemented in Issyk-Kul oblast beginning January 1995. USAID called on the globally funded Health Financing and Sustainability (HFS) Project (implemented by Abt Associates) to provide this initial assistance. HFS Project teams made trips in March-April and June 1994 to provide technical assistance to design the demonstration. During the competitive tender process for its Health Care Finance and Service Delivery Reform (HCFSDR) Project in mid-1994, USAID requested proposals for projects that included intensive demonstration site activities. Further USAID support to Issyk-Kul oblast was provided through this mechanism, renamed the ZdravReform Project when Abt Associates won the tender.

2.2 Pilot Site Selection

The MOH selected a limited area of Issyk-Kul oblast as its first demonstration site in early 1994. The area included the town of Karakol and three surrounding *rayons* (districts) of Dzhetiougouz, Ak-Sou, and Tyup, because of their previous designation as a free economic zone.¹ The area had a relatively strong industrial base, potential mining resources, and high per capita spending levels for health care compared to the rest of the country (\$7 versus \$3 per capita). In 1993, health care expenditures in the demonstration site represented approximately 4.4 percent of oblast income, compared to 3.3 percent nationally. The free economic zone experiment covered about 253,000 people (Langenbrunner, 1995). Additional factors in the selection of Issyk-Kul oblast as the first pilot site in Kyrgyzstan may have been its relative proximity to Bishkek, the fact that both the governor and the head of the oblast health department (OHD) were progressive and interested in health reform, and the manageable size of the territory and population of the oblast (Ibraimova, 2003).

In March 1995, a ministerial decree officially established the free economic zone in Issyk-Kul oblast as the “health insurance” demonstration site and granted greater authority to the OHD to implement pilot activities. In late 1995, the demonstration site was expanded to include the entire oblast – Karakol city and five surrounding rayons, covering nearly 400,000 people (Borowitz and O’Dougherty, 1995).

¹ Free economic zones were established throughout the Soviet Union as pilot programs to gradually introduce market principles and increase autonomy in raising and spending revenues.

2.3 Principal Actors in the Pilot Process

A large number of actors were involved in the Issyk-Kul oblast pilot project. Principal Kyrgyz actors included:

- ▲ Ministry of Health;
- ▲ Ministry of Finance;
- ▲ Issyk-Kul oblast health department;
- ▲ Issyk-Kul oblast finance department;
- ▲ Newly formed family group practices (FGPs);
- ▲ MANAS team set up in 1994 under the MOH to develop a national ten-year health reform master plan; and
- ▲ National Mandatory Health Insurance Fund established in 1997.

The Issyk-Kul oblast health department was very supportive of the pilot, restructuring service delivery, establishing an oblast-level mandatory health insurance fund, and supervising facility-level improvements in efficiency and quality. A USAID evaluation of the ZdravReform Project points out, a “key ingredient [to success] has been a strong oblast health department director who feels a sense of ownership for the reforms and is willing and able to carry out them in the face of local and national opposition” (Laudato et al., 1997).

At the national level, Dr. Kasiev, the Minister of Health in 1994, provided initial strategic direction for the pilot and established an independent national team to develop a health reform master plan. The MANAS team was led by a program coordinator, Professor Tilek Meimanaliev, and included 25 central-level and seven oblast-level professionals who worked full-time in a project office outside of the MOH. The MANAS process placed a strong emphasis on building capacity of the team and of MOH staff at all levels of the system to strengthen the policymaking and management capacity of a group of Kyrgyz experts to support implementation. Capacity-building efforts emphasized improving program management skills, increasing technical knowledge on health system and health reform issues, learning English, and developing basic computer skills.

National capacity-building efforts resulted in the creation of a cadre of highly qualified reform experts. In October 1996, implementation of the MANAS master plan was launched, and it was decided that implementation would be led by the Policy, Planning, and Coordination Department of the MOH led by Dr. Meimanaliev. The MANAS design team was integrated into this coordination unit. In 1997, Dr. Meimanaliev was appointed Deputy Minister of Health and in that position he began to incorporate the entire health reform team into the ministry. In 1999, Dr. Meimanaliev became the Minister of Health and the health reform team (and to a large extent, the health reform agenda) were completely integrated into Kyrgyz institutions.²

² In 2002, President Akaev reorganized his Cabinet of Ministers in the wake of growing political opposition and Dr. Meimanaliev again became Deputy Minister after the appointment of a new Minister of Health.

Donors also supported health reform efforts in Kyrgyzstan. USAID and the British Organization for Development Assistance (ODA) helped design the pilot in Issyk-Kul. During a three-week design trip in June 1994, USAID and ODA worked with the MOH and Issyk-Kul oblast health leadership and local technical counterparts and intensively discussed and debated options and recommendations for a health financing reform pilot. These discussions resulted in an in-depth analysis of the current situation and needs, a debate of intervention alternatives, and initial training in cost accounting and medical information systems to prepare counterparts for various aspects of pilot implementation.

During pilot implementation phases, USAID – through the HFS, ZdravReform, and ZdravPlus Projects (all implemented by Abt Associates) – provided the most significant support to the Issyk-Kul oblast pilot (see sidebar). In early 1995, ZdravReform established an office in the city of Karakol, staffed by Kyrgyz technical and administrative staff and an expatriate site advisor. Technical assistance was provided largely by Abt staff and international consultants based in the United States and ZdravReform’s regional office in Almaty, Kazakhstan. As reforms were institutionalized, long-term on-site expatriate assistance was no longer required; ZdravReform and ZdravPlus gradually were able to reduce their support to the Issyk-Kul oblast pilot. WHO and the World Bank hoped to support evaluation of the pilot to inform their work at the national level; however, a formal evaluation never took place.

Beyond the Issyk-Kul pilot, WHO provided assistance to the Ministry of Health to develop a national health reform strategy and to build counterpart capacity on technical issues, program management, and computer literacy. The World Bank provided the Kyrgyz government with loans for two consecutive health sector reform projects that expanded the Issyk-Kul pilot into additional oblasts and institutionalized many of the reforms at the national level. USAID worked closely with the World Bank to ensure that their technical assistance complemented the material assistance provided by the World Bank project in Bishkek and Chui oblast and at the national level. In South Kyrgyzstan, the Asian Development Bank provided a loan to improve infrastructure and services for health and education. The Swiss Red Cross provided technical assistance to evaluate the effect of national-level health financing reforms on the population.

Involvement of a number of donors in the design of the Issyk-Kul pilot, along with an active ministry-led donor coordination component of the MANAS Program planning process, led to ongoing interaction among pilot site implementers, donors, and national-level stakeholders. Early donor coordination and capacity building among reform stakeholders at pilot and national levels led to recognition by the MOH, and specifically its Policy, Planning and Coordination Department, that donor coordination, led by nationals, was indispensable in achieving results in Kyrgyzstan – “The MANAS Program showed the importance of placing the coordination role in the hands of national

USAID Health Reform Assistance in Central Asia

Health, Financing, and Sustainability (HFS) Project (1990-95) – A globally funded USAID project to improve financing and efficiency of health sectors in developing and transitional countries and address key policy and organizational constraints hindering access to health services of acceptable quality for all citizens. Abt Associates implemented USAID’s HFS Project. USAID/Almaty provided field support funds to the HFS Project for initial assistance in Kyrgyzstan.

ZdravReform Project (1994-2000) – A three-year globally funded USAID project working in Russia, Ukraine, and Central Asia to improve the efficiency, accessibility, and sustainability of health services delivery. Abt Associates implemented the initial ZdravReform Project. USAID/Almaty provided mission funding to award a two-year contract option period for Central Asia to Abt Associates in June 1998.

ZdravPlus Project (2000-05) – A five-year regionally funded USAID project building on the successes of the ZdravReform Project by continuing to provide technical assistance and training to improve the quality and efficiency of health care services in Central Asia. Abt Associates is implementing the ZdravPlus project.

officials and the need for international and bilateral donor agencies to respect this” (WHO/EURO, 1997). The eventual roll-out of the Issyk-Kul health reform model was facilitated by donor collaboration mechanisms established to design the pilot intervention and the national reform plan, as well as active and continuous interaction between oblast and national-level stakeholders.

3. Pilot Design

There is little written documentation from the government of Kyrgyzstan on the pilot design. The government's initial objective was to demonstrate mandatory health insurance (MHI) in one oblast. The design was a radical departure from the previous Soviet system, in that policymakers openly recognized the growing disparity between the level of the benefits and services guaranteed by the state and the shrinking state budget for health. Initial ideas to simply generate additional resources evolved quickly into a pilot design that began to address the excess capacity and inefficiencies inherent in the system. The initial technical approach was revised during 1994 to look at broader health reform that would improve efficiency, examine alternative sources of revenue (beyond MHI), and improve organization and delivery of health care.

The World Bank reports that “an initial proposal was developed by USAID/Abt Associates (see report of July 15, 1994) for the demonstration design and implementation; the proposal was subsequently finalized and agreed upon with the oblast and central governments” (World Bank, 1996). The initial HFS assessment, therefore, seems to represent discussions that took place in 1994 with national and oblast government officials, and provide options and recommendations for pilot interventions based on these discussions. According to the report, the design was amended continuously throughout the initial HFS trip based on technical discussions and on-the-ground assessment of technical feasibility and implementation capacity. The ZdravReform Project, awarded to Abt Associates in fall 1994, used the HFS recommendations as a starting point to develop a work plan and implementation strategy for an appropriate pilot intervention in Issyk-Kul oblast.

3.1 Pilot Objective

The objective of the pilot in Issyk-Kul oblast was to develop or refine a health system design, specifically to demonstrate the feasibility of a mandatory health insurance scheme. Faced with declining GDP and public revenue, the government of Kyrgyzstan clearly identified the need for additional sources of health financing soon after independence. Policymakers had researched financing options and, like neighboring Russia and Kazakhstan, proposed in 1992 to implement an MHI scheme. However, due to the difficult macroeconomic situation, a weak tax base, and limited capacity to design and implement such a system, much uncertainty remained about how MHI would actually work. In early 1994, the government proposed to begin implementation in a demonstration site in Issyk-Kul oblast starting in January 1995, and sought assistance from USAID to implement the pilot.

In addition to the primary pilot objective to develop or refine health system design, ZdravReform viewed the pilot in Issyk-Kul as a way to demonstrate specific designs to provide information and evidence to national stakeholders over time and to simultaneously build capacity for further implementation. ZdravReform's intensive demonstration sites were designed to “provide information to policymakers, develop and demonstrate the usefulness of capabilities in analysis and management, and provide concrete evidence of what can (or cannot) be done....To assist with the process of replicating successes, the Abt team [planned to] rely heavily on collaboration with local counterparts, simultaneously learning from their experience and transferring skills to them” (Sigler et al., 1994).

3.2 Technical Aspects of Design

The main technical objective of early health reform efforts in Kyrgyzstan and the pilot site was to generate additional resources (through insurance) to keep the old system functioning, and decrease reliance solely on the government budget for health care spending. The initial USAID/HFS assessment identified the need for broader restructuring and improved efficiency and quality of care within existing resources, and encouraged policymakers to view these steps as precursors to the establishment of mandatory health insurance, even at the oblast level. Although the more generic objective of the pilot mentioned above – to develop or refine a health system design – did not change as the pilot was being planned throughout 1994, the health system design to be demonstrated expanded in scope significantly based on the assessment, from an MHI pilot to broader health sector restructuring and payment system reform.

The demonstration proposed by the government was to establish a Mandatory Health Insurance Fund organization at the oblast level, financed by a new 6 percent payroll tax on employers and a per capita fee for non-workers from the oblast budget. The government had defined a system for collection and management of funds by the new insurance organization in the Medical Insurance Act. As defined in the act, the goals of the MHI system were to:

- ▲ Increase the level of resources available for spending on health;
- ▲ Allocate available resources more efficiently;
- ▲ Improve the management of service delivery and quality of care; and
- ▲ Decrease reliance on the government for health care spending and allow for more sustainability of funding.

When the HFS team arrived in June 1994, national stakeholders had discussed only vague notions concerning the design of the pilot and had not addressed adequately many financing issues related to the introduction of mandatory health insurance. The trip succeeded in accurately assessing the goals of the pilot, discussing possible technical options, and making recommendations to finalize the design and begin planning the implementation of demonstration site activities. Discussions among the HFS team and Kyrgyz counterparts resulted in an understanding that certain “pre-conditions” were required before mandatory health insurance could be demonstrated fully and effectively, even at the oblast level, and that the set of proposed activities would have to encompass organizational and financing changes more broadly. The trip was successful in reaching consensus on key technical issues, prioritizing agreed-upon interventions, and developing step-by-step implementation plans.

The HFS team’s assessment report found that due to the state of the economy in Issyk-Kul oblast, with rising cost inflation and low salaries, “MHI is unlikely to be able to raise significant amounts of additional revenue by instituting new payroll taxes. At the same time, the effect of new payroll taxes on economic growth may be negative” (Langenbrunner et al., 1994). Based on analysis of existing clinical and economic data, as well as a computer-based simulation model, the HFS assessment team recommended a broader health financing pilot, focused first on addressing the second and third goals of the MHI defined above. “For the next few years, it will be much more important to focus on reallocating existing resources through changes in efficiency” (Langenbrunner et al., 1994). The modeling exercise calculated cost savings associated with reductions in inappropriate lengths of stay and more appropriate use of outpatient care, and led to recommendations on payment system and organizational changes that would contribute to greater efficiency in health care service delivery. Summarized later, the goal of the demonstration project was “to remedy, simultaneously, the

problems of under-funding and inefficiency in the health sector...[with] three major components to the reform project: 1) restructure of the health delivery system; 2) introduction of new incentive-based payment systems; and 3) creation of a health insurance fund” (Purvis, 1997).

Based on the initial discussions of options at the oblast and national levels during the design trip and paired with knowledge of health reform directions in other parts of the former Soviet Union, the HFS report recommended demonstration site activities that would:

- ▲ Shift priority from inpatient to outpatient care and develop multi-specialty outpatient groups;
- ▲ Allow the population to choose their PHC provider to promote competition;
- ▲ Introduce new provider payment systems for hospitals and outpatient facilities, with corresponding quality assurance mechanisms, management information, and cost-accounting systems;
- ▲ Grant facilities more autonomy and decision-making authority; and
- ▲ Establish an oblast-level MHIF to pay for health care and explore options for generating additional revenue.

The immediate focus for the demonstration site was to implement cost-saving measures to improve the efficiency of health care delivery and address some of the deficiencies of the Kyrgyz health delivery system that had been inherited from the former Soviet Union. The assessment report included recommendations to reduce the average length of stay in hospitals, shift inpatient cases to outpatient settings when possible, and pay providers based on admissions and services performed rather than on input measures such as number of beds and staffing.

Based on in-depth analysis of the Soviet system and knowledge of pilot efforts to integrate and strengthen primary health care in Russia in the late 1980s, the report recommended the establishment of independent primary care group practices. These group practices would consist of a pediatrician, an internist, and an obstetrician-gynecologist. To create competition among the practices, patients would be encouraged to enroll with the primary care provider of their choice, and be able to change providers after six months. Payment to group practices would be based on a per capita rate to cover outpatient services only, and the report recommended how the rate and corresponding risk adjustments for the capitation formula were to be calculated.³ Payment to hospitals would initially be made using global budgets provided in lump sums, based on their past budgets, and in six months move to a case-based system. The report also recommended granting more autonomy to oblast governments and health facilities, for example, using performance-based annual contracts rather than state-guaranteed employment to manage medical personnel.

To improve quality, interventions were defined that gathered information on referral rates, enrollment, and resource utilization; supported development of a general practice training program; set up internal quality improvement mechanisms in facilities; and created an independent facility

³ Technical discussions during the assessment trip helped decide key directions for reform. For instance, the assessment trip resolved a debate on payment methods for outpatient services between fee-for-service and capitation. A German-style fee-for-service system had been proposed by a donor organization and piqued Kyrgyz interest, but after discussions during the trip, capitation was recommended to avoid the incentive for physicians to provide more services than necessary, and to minimize the complexity of the payment system given limited resources and technical capacity.

accreditation committee. The report recommended the establishment of medical information systems for inpatient and outpatient episodes of care, using coding systems for operations and procedures, diagnostics, and pharmaceuticals. In addition to clinical data, demographic, financial, and cost accounting data also would be collected and analyzed. Combined, the medical information system would provide information to facility directors to track and manage resources more efficiently and measure improvements in quality and efficiency. Further recommendations in the assessment report outlined steps to establish and build the capacity of an oblast-level MHIF as a single health payer, investigate the feasibility of extending user fees, and refine the government's guaranteed benefits package and eliminate services that were not deemed clinically effective or cost-effective.

3.3 Monitoring and Evaluation Design

The Issyk-Kul pilot design lacked a formal monitoring and evaluation component. The HFS trip resulted in the design of clinical and financial information systems and the development of a health financing simulation model (including output variables) that provided a variety of indicators and data sources that could have been used to monitor and evaluate the pilot project over time. The ZdravReform Project was required to report progress (and results) of its activities to USAID annually. Indicators included the number of primary care group practices formed, the percentage of the eligible population enrolled in the group practices, reduction in referral rates of primary care physicians, reduction in hospital admission rates and lengths of stay, reduction in the number of hospitals beds, and the number of health care facilities with improved quality assurance, financial, and clinical information systems. The World Bank Staff Appraisal Report describing the first health sector loan in Kyrgyzstan required the government to conduct an evaluation of the Issyk-Kul experience to inform design of roll-out activities in Bishkek city and Chui oblast by the end of December 1996.

4. Implementation

Implementation of the health reform pilot is described in the following sections: 1) technical aspects of the pilot intervention in Issyk-Kul oblast; 2) simultaneous national health reform planning efforts; and 3) efforts to connect the Issyk-Kul pilot to national policy and decision-making – the top-down, bottom-up approach.

4.1 Technical Approach

The pilot in Issyk-Kul oblast was launched in 1994. Because the HFS assessment/design document was quite comprehensive and ambitious, recommendations for short-term activities in the report were incorporated into the ZdravReform annual work planning process and pilot interventions were broken down into manageable pieces that would be implemented using a step-by-step approach. ZdravReform worked with oblast-level counterparts to develop a comprehensive, integrated health reform model, consisting of work focused in four areas:

- ▲ Health delivery system restructuring and strengthening of primary care;
- ▲ Population involvement;
- ▲ New provider payment systems; and
- ▲ New management information systems.

The first intervention area – health delivery system restructuring and strengthening of primary care – resulted in the reorganization of service delivery away from large, specialty-dominated polyclinics and hospitals toward a newly developed PHC structure. Family group practices (FGPs) comprising a therapist (internist), a pediatrician, an obstetrician/gynecologist, several nurses, and a practice manager were created as entities capable of providing the entire range of PHC services. “Some of the salient features of the FGP model were: physicians’ ability to choose the group practice and the other physicians with which they wish to affiliate; cross-training among the three specialties; a greater level of clinical autonomy and administrative discretion than existed in the polyclinic structure; continuity of care and a long-term relationship with the patient and the patient’s family; and a business entity approach entailing the development of business systems and introduction of practice managers” (Purvis, 1997). Between 1995 and 1997, several hospitals and outpatient specialty facilities were closed and 81 FGPs were formed in Issyk-Kul oblast.⁴ Doctors from the FGPs received family medicine training and an FGP association was established to support the development and strengthening of FGPs. Grants from ZdravReform and Mercy Corps to FGPs through the FGP Association provided much-needed funds for minor renovation, clinical equipment, and even computers.

⁴ Over time, as FGP autonomy increased, the 81 FGPs that had been initially established voluntarily merged to combine resources, resulting in 74 functioning FGPs in Issyk-Kul oblast in 2000.

Timeline of Health Reforms in Kyrgyzstan
1992
Government of Kyrgyzstan passes Health Protection Act and Law on Medical Insurance
1994
Memorandum of Understanding signed between WHO/EURO and MOH to undertake the MANAS Health Care Reform Program
Government of Kyrgyzstan requests USAID technical assistance in health care financing reform and plans pilot in Issyk-Kul oblast
Health Financing and Sustainability (HFS) Project sends a team to help develop a health insurance reform demonstration in Issyk-Kul oblast
National Health Policy developed and approved by government
USAID awards Health Care Financing and Service Delivery Reform Program in Russia, Ukraine, and Central Asia to Abt Associates (later renamed ZdravReform Project)
1995-96
Restructuring of primary health care in Issyk-Kul oblast, including development of new family group practices, introduction of family medicine, open enrollment, and development of new provider payment and health information systems
Government approves MANAS Health Care Reform Program
World Bank-funded Health Sector Reform Project begins (1996-2000) in Bishkek city and Chui oblast
1997-99
Introduction of mandatory health insurance; 13 hospitals contracted with MHIF
MHIF brought under MOH
MHIF expands to 66 hospitals and 290 family group practices
Roll-out of FGP formation and open enrollment to Bishkek and Chui oblast
Budget funds (republican, oblast, city, rayon) pooled in Issyk-Kul
Meimanaliev appointed Minister of Health
Roll-out to South Kyrgyzstan and formation of first FGPs
2000
MANAS health reform team institutionalized into MOH, MHIF, and other health sector entities
USAID awards five-year Central Asia Quality Health Care Project to Abt Associates (later renamed ZdravPlus Project)
2001
Single-payer system established and pilot tested in Issyk-Kul and Chui oblasts
Development of monitoring and evaluation efforts (WHO/Department for International Development)
Co-payment policy introduced in single-payer system pilot sites; evaluated by Swiss Red Cross
Clear positive results in Issyk-Kul and Chui including rationalization of beds, buildings, and staff; reinvestment of savings; increases in salaries; reduction in fixed costs; population accepts co-payment and does not pay more
Extensive policy dialogue on FGP model; move to mixed model of FGPs and family medicine centers for roll-out
World Bank-funded Health Sector Reform Project II begins

Involvement of the population was encouraged through open enrollment and free choice of FGP. Increased population participation in health care decision making held providers more accountable for providing high quality services and allowed patients to change providers if they were not satisfied with their care. Issyk-Kul oblast was the first health reform site in the former Soviet Union to guarantee free choice of primary care provider to its population, beginning what Deputy Minister of Health Tilek Meimanaliev refers to as “the democratization of health care” (Meimanaliev, 2003). Local marketing teams conducted public awareness, consumer choice, and enrollment campaigns with much success. By 1996, approximately 85 percent of the population had taken part in open

enrollment and selected an FGP. The marketing teams also worked through a variety of media channels to increase the population's knowledge of key health issues that affected them.

The third intervention area introduced new provider payment systems. Payment systems were designed to introduce competition and pay providers based on services provided, not on historical budgets or input measures such as number of staff. The payment system provided financial incentives to FGPs to increase patient load and reduce referrals, especially when accompanied by increased facility autonomy, updated equipment, and enhanced clinical skills. New FGP payment systems were started in 1998. FGPs received payment from the national health insurance fund (HIF) and an oblast budget pool based on a capitated rate. Funds from the HIF were used primarily for recurrent costs – salaries, supplies, and emergency drugs – while funds from the oblast budget were used largely to cover the facility's fixed costs. Institutional capacity building and development of the oblast HIF resulted in the existence of an entity capable of serving as a health purchaser. A new case-based hospital payment system was developed in Issyk-Kul in 1996 and became the basis of a similar national system in 1997. From June 1998-2000, the oblast hospital and all central rayon hospitals in Issyk-Kul were paid under the new case-based hospital payment system. The pilot in Issyk-Kul oblast formed the argument to replace many fragmented funding pools with a single health system payer and developed hospital, outpatient, and PHC provider payment systems, along with associated cost accounting, billing, and information systems.

Finally, the pilot in Issyk-Kul oblast helped the 81 FGPs develop new management, financial, and clinical information systems to help them operate more like independent business entities. The information systems provided data to develop and refine the new provider payment systems and served as management tools for facilities when the new payment systems were implemented. A new position within the FGP of a practice manager was created and a cadre of practice managers was trained and dispatched to help the FGPs adapt to the new provider payment systems. Quality assurance activities helped mitigate any negative consequences of the new payment systems and began to encourage better quality of care through continuous quality improvement processes rather than strict quality control. A licensing and accreditation program was developed and all FGPs in Issyk-Kul were accredited by 1999 to be eligible for payment by a capitated rate per enrollee by the insurance fund.

The initial design and implementation period was spent in “splendid isolation” – working intensively at the oblast level with little interference from national policymakers (O'Dougherty, 2003). The designation of the oblast as an official pilot site, and the presence of a ZdravReform site advisor and field office, allowed the Ministry of Health to grant oblast health leadership a great deal of autonomy and give the pilot a valuable asset needed to succeed: time. “Elements of the health reform foundation such as training health policymakers and health professionals about reform and new management principles, restructuring the health delivery system, clinical training, educating the population, and establishing information systems all take time as they involve building physical and human capacity....this foundation, once established, continues to pay dividends over the long-term” (Hafner et al., 1999).

4.2 National Health Reform Planning

Parallel and simultaneous to early reform efforts in Issyk-Kul oblast, the MOH and the WHO Regional Office for Europe (WHO/EURO) signed a memorandum of understanding in March 1994. In the memorandum, the MOH expressed its interest in developing a ten-year master plan (1996-2006) for the health care system and WHO agreed to provide the necessary technical assistance and capacity building. The process to develop the master plan, later named the MANAS Program, resulted

in a strategic vision and flexible blueprint for national health care reform, effective donor collaboration mechanisms, and increased capacity among national- and oblast-level health reform stakeholders.

Development of the MANAS Program took place in several phases, including situation analysis, development of strategic policy options, and development and refinement of the details of the Program. The MANAS Program developed short-, medium-, and long-term strategies for health care reform, while improving managerial capacity in the health system at both the national and regional levels. The plan included strategies to rationalize excess capacity in the health system and redirect savings to strengthen primary health care. In health financing, the plan outlined strategies to increase sources of funding, improve resource allocation, and introduce new provider payment systems. The MANAS Program planned to reorganize PHC and hospital services, and to better manage and invest in human resources. The plan specified steps to improve clinical information systems.

Development of the MANAS Program resulted in creation of a strategic vision for the health care system in Kyrgyzstan through a comprehensive planning process. The master plan set directions for the health system, but also recognized that technical details could be worked out later. Flexibility inherent in the master plan contributed to its ultimate success. Dr. Meimanaliev notes, “we didn’t feel we had to follow it to the letter” (Meimanaliev, 2003). Ainura Ibraimova, General Director of the MHIF, states that “From the beginning, we said that MANAS is a working document – it’s not the bible, it’s not dogma, it should be a flexible vision....the health sector is too dependent on politics, economics, and priority setting so the Program set out just the broad strokes, leaving the rest to implementation” (Ibraimova, 2003). The MANAS Program contributed to the reform process by officially providing governmental support for health reform and giving reformers a “flag behind which to marshal forces for change” (O’Dougherty, 2002). In the long run, the mere existence of the strategic vision and high-level government support of the agreed-upon vision proved more important than the technical details or proposed timeline of the master plan. In fact, many aspects of the reforms were not implemented according to the master plan.

Donor collaboration, led by Kyrgyz reform experts, was a key element of the development process of the MANAS Program from the very beginning. The vision provided by the master plan established a framework or umbrella under which all donor and pilot activities could be coordinated. The design process was inclusive of all donors working in the health sector, including USAID and the ZdravReform Project working in Issyk-Kul oblast, and was consensus-based to the extent possible. This set the precedent to continue engaging and coordinating donors during implementation of the master plan. “The MANAS Program showed the importance of placing the coordination role in the hands of national officials and the need for international and bilateral donor agencies to respect this” (WHO/EURO, 1997). Because resources in Kyrgyzstan, both budget and donor, were often limited, it was important that their use was well coordinated for maximum impact. Currently all donor activities are actively coordinated by the Deputy Minister of Health, who connects each donor activity to broad national health reform efforts (Meimanaliev, 2003).

4.3 Top Down, Bottom Up

The MANAS Program represented a top-down approach – a centrally planned vision for the health reform sector. The Issyk-Kul oblast pilot site represented a bottom-up approach – actual implementation of a comprehensive and integrated health reform model. The two approaches came together in late 1996 and early 1997. The Ministry of Health planned to begin implementing the MANAS Program and took an interest in the experience and lessons learned from the Issyk-Kul oblast pilot. In Issyk-Kul, oblast leadership and the ZdravReform Project were beginning to feel that

certain aspects of the reform model, especially related to health insurance, health financing, and pooling, would have to be resolved at the national level.

The top-down, bottom-up approach created great synergies as the strengths of one approach covered the weaknesses of the other. The convergence of the MANAS Program and the Issyk-Kul pilot provided much of the initial momentum for reform. The MANAS Program did not actually implement reform, leaving the Kyrgyz reformers without operational experience or the visible symbol of reform needed in post-Soviet society. The Issyk-Kul pilot was initially considered an isolated test and did not have the high-level political support engendered by the MANAS master plan. The pilot, however, delivered tangible results that were felt both by health providers and the population, and that had national policy relevance. Policy dialogue can occur without implementation; however, implementation experience allows the policy dialogue and development to take on greater meaning and tends to result in decisions and movement rather than just more dialogue. The pilot also determined and tested technical inputs that would later be applied to the entire reform program (O'Dougherty, 2002).

The connection between the top-down and bottom-up reforms became more formal over time. Certain pilot-level interventions, especially related to health financing issues and family medicine training, inherently needed political support, policy, and regulation at national levels. At the national level, a joint working group (JWG) between the MOH and the national HIF was established in 1996 to coordinate health financing policy reform. The JWG provided a mechanism for discussion and resolution of technical issues, as well as careful consideration and planning of how they actually would be implemented. The JWG defined principles that would guide the development of systems to support health financing reform. The systems would: 1) fit into the comprehensive, long-term framework for coordinated health reform policy (MANAS); 2) be simple but technically advanced and viable; 3) be realistic to allow practical implementation; and 4) *where possible, would adapt and use the systems developed and tested in Issyk-Kul oblast* (O'Dougherty, 1998).

Design of the first World Bank health sector reform project in 1995-96 also helped formalize the top-down, bottom-up approach. The design process of the first World Bank project provided a platform for national discussions of the health reform and health financing model tested in Issyk-Kul and for resolution of barriers to further implementation in Issyk-Kul. The project had four components: primary health care, facility rehabilitation, provider payment, and pharmaceutical management. The MANAS Program viewed the loan as a way to finance implementation of their master plan for the Kyrgyz health sector. The design explicitly connected experience from the Issyk-Kul pilot to national-level health policy and financing reform and to the expansion of the Issyk-Kul model to two additional pilot sites – Bishkek city and Chui oblast. It also helped address any remaining barriers inhibiting development of provider payment reforms in Issyk-Kul, making “a condition of negotiation for the project that a Presidential decree and government edict are issued which remove any barriers to the implementation of new provider payment systems in the Issyk-Kul pilot” (World Bank, 1996). A second loan would finance countrywide expansion and further institutionalization of reform efforts.

5. Monitoring and Evaluation

There was little formal monitoring and evaluation of the initial pilot health reform intervention in Issyk-Kul oblast. The original design included medical information systems to complement health financing reforms, with data and data systems providing “the basis for comparison, evaluation, planning, and future decision-making” (Langenbrunner et al., 1994). These systems would be embedded in the reforms, however, and not provide the kind of formal evaluation often desired before making a decision whether reforms were successful or not, or deciding whether or not to roll them out.

In 1994-95, Kyrgyzstan was selected from the WHO/EURO region to be part of a WHO effort to evaluate health financing reforms in each of WHO’s six geographic regions. It was decided that the pilot in Issyk-Kul oblast would be selected as it was starting to provide a basis for overall reform of the health system and the MOH was interested in documenting the experiment. USAID was happy to cost-share with WHO, as there were not sufficient funds at the time for both implementation and a formal evaluation. Work was begun in 1995-96, but inappropriate selection of local counterparts to conduct the evaluation led to significant delays.

In designing the first health sector loan in 1996, the World Bank was impressed with the reforms that had taken place in Issyk-Kul oblast and wanted to roll them out to Bishkek and Chui oblast, but only after a formal evaluation. The Kyrgyz government agreed to conduct the evaluation as part of the conditions of the loan. No guidance was given on the content of this evaluation. However, the Staff Appraisal Report (World Bank, 1996) expected the provider payment reforms in Issyk-Kul to result in a decrease in the number of inpatient admissions, average length of stay, and the number of secondary referrals, with a simultaneous increase in the number of outpatient visits. Additional indicators that were suggested included the proportion of health sector resources allocated to the primary care sector, the number of beds and facilities closed, the number of family group practices formed, and the percentage of the population enrolled in family group practices.

In 1997, WHO designated a new Kyrgyz counterpart to resume the work that both WHO and the World Bank had requested and to develop a detailed evaluation proposal. But by the time the proposal was completed, the decision to roll out the Issyk-Kul oblast reforms already had been made, and neither an evaluation nor a subsequent report were ever finalized. However, the MOH (with assistance from ZdravReform) prepared a preliminary review of results and impact of the World Bank-financed Kyrgyz Health Sector Reform Project during the design phase of the second loan project. The review describes many results in terms of process and outputs, as well as reduced hospital length of stay and decreased PHC referrals, two key indicators of performance under the reformed health system.

Despite the lack of a formal evaluation, health reforms that were piloted in Issyk-Kul oblast were rolled out to additional oblasts. Due to the parallel development of a national health reform program, national leadership was open to health system reform and interested in what was happening in Issyk-Kul. These leaders visited Issyk-Kul oblast and participated in joint working groups on technical and implementation issues relating to the pilot, while Issyk-Kul oblast representatives participated in development of the MANAS Program. This interaction provided informal evidence of what worked

and what did not work in Issyk-Kul oblast, and allowed policymakers and implementers to slightly adapt the health reform model based on this evidence. As noted in Hafner et al. (1999), “[t]he first two years of the pilot site were formative and in many ways defined the parameters determining subsequent results.” The basic health reform model was developed and the premises and parameters tested in Issyk-Kul were largely consistent throughout expansion and roll-out.

The World Bank loan itself provided a mechanism to finance roll-out to two additional oblasts. A key lesson learned in the need for pilot evaluation may be that formal evaluation is less of a priority when the national health policy context is conducive to reform and roll-out and when key stakeholders understand and accept the health reform model that is being tested. Monitoring and evaluation became more important in Kyrgyzstan in the second phase of piloting when options to further refine the broad health reform model were tested, such as patient co-payments and an outpatient drug benefit for insured populations.

6. Pilot Outcomes

The pilot project in Issyk-Kul was successful in a number of ways. The pilot resulted in the reorganization of the oblast health care delivery system and opened the way for improvements in efficiency and quality of care. Positive results obtained in Issyk-Kul oblast and other pilot sites have led to expansion of the reform model to additional oblasts and institutionalization of health reform at the national level. In 1996-97, the Issyk-Kul pilot was connected to national-level health reform policy, and planning and reforms were rolled out from Issyk-Kul oblast to the city of Bishkek and Chui oblast between 1997 and 1999. In 2000, health reform in Kyrgyzstan began the final stage of institutionalizing health reform at the national level and expanding reform efforts to all seven oblasts. Implementation of the model built capacity to implement at oblast and national levels and familiarized stakeholders with the benefits of piloting.

6.1 Reforming Health Care Delivery in Issyk-Kul Oblast

The major accomplishments of the initial pilot in Issyk-Kul oblast can be summarized as follows:⁵

- ▲ Eighty-one new FGPs were formed in stages from early 1995 through mid-1996. From June 1998-June 2000, the legal status of the FGPs was solidified and technical assistance and training largely succeeded in establishing FGPs as the foundation of a new health delivery system structure.
- ▲ Through an evolutionary process reflecting increased autonomy at the FGP level, FGPs voluntarily merged to combine resources, resulting in 74 currently functioning FGPs in Issyk-Kul oblast.
- ▲ FGPs were strengthened through the provision of family medicine training for FGP physicians and nurses in Issyk-Kul oblast from 1996 through the present. Eight physician trainers were trained, who in turn trained 215 oblast physicians in family medicine using a four-month retraining course. Nurses from Issyk-Kul oblast also were retrained in family medicine. The Family Medicine Training Center (FMTC) in Issyk-Kul oblast was institutionalized as an affiliate of the Post-Graduate Institute's National FMTC.
- ▲ FGPs began to incorporate infectious diseases and reproductive health into PHC.
- ▲ A new health sector NGO, the FGP Association, was established in 1996. The Association established a voluntary board structure and developed their capabilities to provide services to their member FGPs.
- ▲ More than 85 percent of the population was enrolled in FGPs as a result of intensive marketing campaigns held over the last half of 1996. The population database based on

⁵ This section was excerpted and updated from Borowitz, et al., June 2000.

enrollment was strengthened and used as the basis for capitated rate payment to FGPs.

- ▲ Extensive health promotion campaigns on a variety of health topics were conducted using mass media and other dissemination channels, such as informational brochures and community meetings.
- ▲ Institutional capacity building and development of the oblast MHIF resulted in the existence of an entity capable of serving as a health purchaser.
- ▲ A new case-based hospital payment system was developed in Issyk-Kul in 1996 and became the basis of the national MHIF hospital payment system initiated in late 1997. From June 1998 to June 2000, the oblast hospital and all Central Rayon Hospitals in Issyk-Kul were paid under the new case-based hospital payment system.
- ▲ In the fall of 1998, the national MHIF tested a new capitated rate payment system for FGPs in Issyk-Kul oblast. All 74 FGPs in Issyk-Kul now are being paid under this new MHIF system. In 1999, the national MHIF extended this FGP capitated rate payment system to all FGPs nationwide.
- ▲ In 1998, a new FGP capitated rate payment system for budget funds was developed and tested in Issyk-Kul.
- ▲ New health information systems for both the health purchaser and health provider were developed, tested, implemented, and refined in Issyk-Kul oblast and later implemented at the national level.
- ▲ A new health sector career – FGP practice manager – was established and developed.
- ▲ A policy and legal framework for health reform was developed.

6.2 Expanding Reforms Geographically

6.2.1 Rolling Out Reforms to the City of Bishkek and Chui Oblast

Reforms tested in Issyk-Kul oblast were rolled out to the city of Bishkek and to Chui oblast starting in late 1996 under the auspices of the World Bank Health Sector Reform Project. In 1995, senior leadership at the World Bank were impressed with the Issyk-Kul pilot and hoped roll-out of the model would balance their desire to develop a more efficient, sustainable health delivery system for the long term with the MOH's desire to address their critical short-term health and humanitarian needs. Over the next year, the ZdravReform Project contributed substantial technical assistance to the design of the first World Bank Health Reform Project in Kyrgyzstan. The World Bank and the MOH selected Bishkek city and Chui oblast as pilot sites for several reasons: 1) relatively dense, urban population; 2) relative affluence; 3) sophistication of personnel and institutions; 4) excess of medical providers; 5) proximity to each other; 6) proximity to health sector leadership; and 7) proximity to technical coordinating staff (World Bank, 1996). When the World Bank Project became effective in late 1996, ZdravReform began to collaborate with the Project in the roll-out of the Issyk-Kul health reform model to Bishkek city and Chui oblast. Because the Kyrgyz government did not want to borrow substantially for technical assistance the basis of World Bank and USAID collaboration was formed on the following principle: USAID would provide the significant technical assistance for

which the government was reluctant to borrow and the World Bank loan would provide substantial investment in commodities and political leverage.

As had been done in the Issyk-Kul pilot, the World Bank Project defined four major program elements of the provider payment component: 1) comprehensive restructuring of the primary care sector; 2) free choice of primary care provider by the population; 3) incentive-based provider payment systems for primary care, outpatient specialty services, and hospital services; and 4) management, information, and quality assurance systems. In early 1997, experienced ZdravReform local staff were relocated from Issyk-Kul to Bishkek in order to establish an office and begin implementation of health reform in Bishkek city and Chui oblast in collaboration with the World Bank. The Project planned to refine and adapt the Issyk-Kul technical interventions for the population composition and urban health service delivery structure in Bishkek and Chui oblast. For instance, family group practices were located within mixed (multi-profile) polyclinics and there were more physicians per FGP. Family Medicine Centers were established to coordinate payment to individual FGPs and consolidate accounting and information systems functions.

The roll-out of health reforms to Bishkek city and Chui oblast moved rapidly. By late 1999, 108 FGPs had been formed in Bishkek city and 144 FGPs had been formed in Chui oblast. As of June 2000, the task of strengthening FGPs was proceeding well as FGPs had received equipment, renovations, and clinical training. In late 1998, over 80 percent of the population of Bishkek city and Chui oblast, more than one million people, exercised their right of free choice of PHC provider and enrolled in the FGP of their choice. Health promotion campaigns began to increase the responsibility of the population for their health status. National health sector NGOs – FGP and Hospital Associations – were established, and their capability to advocate and provide services to their members increased. New provider payment systems and health information systems were developed, tested, and implemented under the MHIF (Borowitz et al., 2000).

6.2.2 National Roll-out by Oblast

During the design of a second World Bank loan project, plans were developed to roll out reforms geographically – to Osh and Jalal-Abad oblasts in South Kyrgyzstan in 1998 (in collaboration with the Asian Development Bank's rural infrastructure project) and to Naryn, Talas, and Batken oblasts in 1999-2000. Initial steps in rolling out to these sites included forming FGPs and FGP associations, and enrolling populations. Nationally, 27 family medicine centers were established along with 748 FGPs. As of November 2002, more than 2000 physicians (80 percent of all PHC physicians) and more than 1700 nurses (50 percent of all PHC nurses) had been retrained in family medicine (Fonken, 2002). In stages, FGPs and other health facilities were included in national-level provider payment systems through the MHIF and in family medicine retraining efforts. Information systems were introduced to support financing systems and inform facility management.

6.3 Informing National Policy

Technical interventions tested in Issyk-Kul oblast informed national health reform efforts. Health reforms were institutionalized at the national level in a variety of ways between 1997 and the present. As mentioned, the MANAS Program was developed as a flexible blueprint to guide health system strengthening. A cadre of progressive, well-trained health reformers was gradually institutionalized at the MOH and MHIF. A process-oriented approach through a joint working group and subcommittees on technical issues was established to develop the policy and legal framework for health reform and a step-by-step approach to implementation. A guiding principle of this approach was to use what had

been developed and tested in Issyk-Kul. Technical interventions such as provider payment and clinical information systems were taken wholesale from the Issyk-Kul pilot or adapted for use nationally or in other oblasts. Conditions of the first World Bank loan included resolution at the national level of many of the outstanding issues in health financing and provider payment that had been confronted during implementation of the Issyk-Kul oblast pilot. A second World Bank loan was designed in 2001 to expand reform countrywide and to continue deepening national reform efforts in health services delivery restructuring, health financing, quality improvement, and public health. Two specific examples of how the Issyk-Kul pilot experience informed national-level policy formation and health reform are presented below.

6.3.1 National Mandatory Health Insurance

Even without a fully functioning oblast-level health insurance system in Issyk-Kul, technical details elaborated in the pilot site from 1994-96 were used to support the creation of a national MHIF in January 1997. Specifications for provider payment systems for hospitals and PHC facilities, clinical statistical groups (for hospital payment), and information systems developed in Issyk-Kul were taken wholesale by the MHIF in 1997 and adapted over time. As the MHIF's Ibraimova, says, "We practically took [them] straight from Issyk-Kul oblast to start, and just simply introduced them... We immediately wrote a decree that approved the clinical statistical groups and we took them as they were, almost exactly, including the information system, only making minor modifications to the clinical information form for instance, and introduced them into the facilities where the MHIF began to work" (Ibraimova, 2003).

The MHIF also adopted the step-by-step approach used to implement health system reforms in Issyk-Kul. Dr. Ibraimova recalls that they realized it was "better to work out details of one step before moving forward to the next step" (Ibraimova, 2003). The MHIF's plan was to gradually expand coverage by population category – workers, pensioners, unemployed, then children and to gradually increase the number of facilities reimbursed with health insurance funds. From March to June 1997, the MHIF developed methodology and approaches to prepare to start financing in the second half of the year. They decided to work first with hospitals, as they were more prepared than the new FGPs. In June 1997, the MHIF contracted with one hospital. By the end of 1997, they contracted with all 13 national hospitals and over time contracted with 66 general hospitals throughout the country. By the end of 1998, the MHIF began contracting with FGPs as they were formed, paying them using a capitated rate payment system.

The MHIF was recently transferred under MOH authority to act as a single payer of funds to health care providers. Today, the MHIF pools funds from various sources (budget funds, health insurance payroll, taxes, and population co-payments) and reimburses health facilities for health services provided to the population. The MHIF distributes health care resources using provider payment systems with financial incentives to increase efficiency – a capitated payment system for PHC facilities and a case-based payment system for hospitals (Livelsberger and O'Dougherty, 2002).

6.3.2 Single-payer System

Efforts to reform health financing have resulted in a model with worldwide relevance – a single-payer system that pools health care resources and redistributes them through provider payment systems with incentives to improve efficiency and quality. Restructuring and rationalization have reduced excess health system capacity. The single-payer system can largely be credited with creating an impetus for behavior change in the areas of reducing hospital overcapacity and reinvesting savings.

Issyk-Kul oblast piloted the single-payer system in 2001. Excess capacity was rationalized, with the number of beds being reduced by 32 percent, the number of buildings reduced by 30 percent, and staff reduced by 13 percent. Staff salaries increased by 20 percent, funding for patient supplies and other direct costs increased by 116 percent, and expenditures on drugs per patient-day increased by 170 percent. Results of the single-payer system pilots in Issyk-Kul and Chui oblasts convinced President Askar Akaev to endorse their replication on October 16, 2001: “Success of the Issyk-Kul and Chui oblast pilots in implementing new methods of health financing, including co-payment mechanisms [have] led to a sharp decrease in corruption in health care facilities, as well as an increase in revenues that allow for improvements in the quality of care. These new, positively tested methods of health care organization should be spread countrywide.”

This core structural and financing reform in the health system provides the foundation for additional interventions that change the behavior of stakeholders in the health system, like an outpatient drug benefit and formalized co-payments. The outpatient drug benefit has resulted in more of the population being insured, increased availability of drugs at FGPs, increased utilization of primary health care, and reduced hospital referrals and admissions. Formal co-payments for specialized outpatient and inpatient care have reduced informal payments to doctors and for drugs, and significantly increased facility resources available to improve quality of care (McEuen, 2002).

Currently, the MOH is working to include continued introduction of the single-payer system and timely transfer of funds from the Social Fund to the MHIF as conditionalities of upcoming structural adjustment credits and therefore better ensure sustainability of health financing reforms.

6.4 Building Capacity to Implement Health Reform

The management skills required to formulate and implement plans were not well developed in the Central Asian health sector, in part because the Soviet system did not put a premium on problem solving or risk-taking behavior. Health reform efforts, at pilot and national levels, have been accompanied by significant investments in building capacity to implement health reform. This has occurred through training, exchanges, and study tours, but perhaps most importantly through actual implementation by counterparts together with donors. This approach created a health reform foundation that made evolution of reforms more inevitable and relied on small successes to build confidence, increase interest, and ultimately contribute to big successes.

It is important for Issyk-Kul to continue to stay a step ahead and serve as a visible leader and symbol to facilitate the introduction of health reform in other parts of the country: “A pilot never ends, there is always continuous learning as the pilot goes deeper” (Ibraimova, 2003). Issyk-Kul oblast remains to this day a test site for subsequent steps in Kyrgyz health reform, such as the single-payer system and the introduction of facility-level quality improvement systems. In addition, the Ministry of Health is testing new models of providing emergency care and ambulance services in Chui oblast and experimenting with hospital restructuring and management in Naryn oblast. In contrast to the initial Issyk-Kul oblast pilot, these subsequent pilots aim to test and refine more specific and narrow health reform interventions and have been more rigorously and capably evaluated by the MOH and the MHIF, with support from WHO and other donors. Evaluation and implementation experience has led to refinement and phased implementation of the single-payer system and the outpatient drug benefit, as well as expansion and roll-out of facility-level quality improvement systems.

7. Lessons Learned

The Issyk-Kul oblast demonstration site was very successful in building a foundation for health reform in Kyrgyzstan. The pilot project in Issyk-Kul and health reform efforts more generally were successful for a number of reasons. The health reform model was appropriate to the Kyrgyz setting, the political context was conducive to reform and experimentation, and a consistent, yet flexible vision was developed to guide reform efforts. A step-by-step operational approach and well-defined processes (pilots, joint working groups) to plan, discuss, problem solve, and evaluate health reform implementation enabled counterparts to learn by doing, use evidence to inform decisions, manage crises, and institutionalize health sector decision making. Consistent and knowledgeable counterparts (turned health reform champions) were critically important to success, as were high quality technical assistance and effective donor collaboration. The initial pilot, subsequent roll-out, and national institutionalization were made possible through committed local financing, health sector savings from rationalization, two World Bank health sector loans, and other donor financing for technical assistance.

7.1 Appropriateness of the Health Reform Model

The pilot intervention was well researched and appropriate to the country setting. Pilot site selection capitalized on an earlier pilot to stimulate economic growth. The design of the technical intervention incorporated and expanded late Soviet thinking and piloting on PHC restructuring – decentralized health financing and the integrated FGP model (Russian acronym is APTK). The model was developed through an environmental assessment of both conceptual and management strengths, weaknesses, opportunities, and threats. Because many of the problems in the health sector were at the core of the health delivery and financing system, addressing them required dismantling and rebuilding the health system foundation. Health financing reform required changes in the health service delivery system to strengthen primary health care and to optimize an excessive hospital sector. Changes in clinical practice required intense training for health professionals and changing the roles and relationships of providers, patients, and communities. The model and proposed interventions were developed in active collaboration with Kyrgyz experts during the design of the Issyk-Kul oblast pilot project (1994) and the parallel design of the MANAS Program (1994-96). The two models converged and were re-confirmed during the subsequent design of the World Bank health project in 1996-97.

7.2 Political Context

The health reforms in Kyrgyzstan, including the success and expansion of the Issyk-Kul pilot project, have benefited from political stability and continuity among the major stakeholders. Many of the counterparts that WHO trained in health reform topics, English language, and program management at the national level and that ZdravReform and ZdravPlus have trained in Issyk-Kul oblast have been institutionalized in local governing organizations and remain actively involved in health reform. Despite some recent political wrangling, Dr. Meimanaliev, the MANAS Program Coordinator, remains in a high position in the Ministry of Health and still coordinates health reform efforts nationally.

The level of political will was conducive to the initiation and success of the pilot. At the national level, there was early political support for the pilot and then a hands-off attitude during initial implementation. In the early stages of a pilot, O'Dougherty defines appropriate political support as waivers to try new things, removal of obstacles, and time, space, and tacit approval to experiment (O'Dougherty et al., 2003). If the process is too politicized or the stakes are too high, the pilot risks failure. But oblast-level support at early stages of the pilot also was crucial.

As the pilot matured and the MANAS Program was more fully developed, political interest in the Issyk-Kul pilot intensified. At the same time, implementation of the pilot required inputs from the national level to continue to move forward. Appropriate political will at this stage of the pilot included interest in what had been accomplished in Issyk-Kul, informal assessment of the health reform model that had been implemented, including what had been successful, and a willingness to consider adapting and rolling out successful aspects of the model. The MANAS Program provided the policy framework for national roll-out and the World Bank project provided initial financing to roll out to two additional sites. Reform implementers from Issyk-Kul oblast, host country counterparts and ZdravReform staff, provided the operational experience and expertise to adapt the reform model and begin step-by-step implementation in the new pilot sites. A USAID evaluation concluded that the Issyk-Kul oblast pilot was ultimately successful because of “strong support by the national and oblast governments and a clear commitment to health care reform” (Laudato et al., 1997).

7.3 Health Reform Vision

Health reform in Kyrgyzstan was successful because Kyrgyz reformers had a long-term vision for the health sector. The goal of the health reform model being piloted was to create sustainable system-wide improvements, removing obstacles, and establishing room for improvements in efficiency and quality of care in facilities at all levels of the system. Due to the large and powerful nature of the Soviet health system inherited in Kyrgyzstan, it was understood that starting with facility-level interventions would not create sustainable system change over time. The pilot program, therefore, was designed to test approaches that would inform gradual and long-term system-level change, and not instantly bring a small number of health facilities up to Western standards with little impact on the broader health system.

The MANAS Program provided a blueprint and parameters for the Kyrgyz health reform vision, while the pilot in Issyk-Kul helped develop the skills and approaches to implement the vision. Experience from Issyk-Kul oblast informed development, refinement, and implementation of the MANAS Program and was constantly connected to the larger health reform picture after a period of initial implementation (1994-96). The MANAS Program provided a framework to coordinate all donor work and World Bank assistance. Because the Program was flexible rather than dogmatic, it allowed for innovation during implementation to refine technical details. In fact, many aspects of reform were not implemented according to the technical specifications or timeline defined in the MANAS Program. These changes did not negate the authority of the MANAS Program but seemed to enhance it, because they were based on actual implementation experience in Issyk-Kul and other pilot sites. According to Ibraimova, “life corrected the MANAS Program – the broad strokes are still correct, with slight modifications based on experience” (Ibraimova, 2003).

7.4 Implementation Approaches

Kyrgyz health reform has benefited from several implementation approaches: 1) step-by-step implementation; 2) planning, implementing, and evaluating health policy and technical interventions through joint working groups; and 3) piloting reform interventions. The step-by-step implementation approach broke down technical interventions and even complex health sector reforms into manageable pieces and the likelihood for successful implementation of each piece became greater. The Issyk-Kul oblast pilot “showed that it was not possible to introduce health insurance immediately, at one moment, and we learned the principle, the step-by-step approach...better to work out details of one step before moving forward to the next step...all of this reform would never have been possible if not in steps...” (Ibraimova, 2003).

Step-by-step implementation is also important for successful capacity building. If reforms are pushed too quickly by top-down planning and legislation, implementation gets ahead of capacity, and local partners become frustrated and are unlikely to claim ownership of the reform process. This can create a dichotomy between the daily work of the health sector, which is carried out by health sector professionals, and health reform activities, which are carried out by technical assistance providers. If reforms are implemented gradually and allowed to follow a natural process of expansion, ownership and sustainability are more likely, roles and responsibilities become clearer, and demand from local partners drives additional capacity building from donors and elsewhere so it is more timely and relevant (Borowitz et al., 1999).

Joint working groups were developed with donor support as a democratic and participatory mechanism for policy dialogue and process. JWG enhance policy dialogue and build capacity for both broad policy and planning, as well as narrower technical issues, often across institutions. JWGs can protect the policy process against political instability, as JWG participants tend to be more stable than political leadership. These JWGs served in Kyrgyzstan as a forum for planning health reform activities, involving inter-sectoral partners, and ensuring donor and project communication and collaboration.

As discussed throughout this paper, pilot sites in Kyrgyzstan, and the Issyk-Kul oblast pilot in particular, helped develop a health reform model, refine technical design, and test implementation feasibility. The Issyk-Kul pilot helped develop specific, detailed elements of the health reform framework, upon which a national legal and policy framework could be based. The Issyk-Kul pilot and its subsequent roll-out also played an essential part in capacity building as oblast counterparts gained experience with the day-to-day implementation of reforms, then become advocates for reforms and an important source of technical assistance for national policymakers, other oblasts in the country, and for other republics. In addition, the Issyk-Kul pilot was crucial in overcoming resistance to health reform. Operational implementation of health reforms that produced visible changes in pilot sites led to a shift in the opinions of health sector decision makers and increased support for early progressive health reformers. As with policymakers, the pilot helped convince health professionals and the population that health reform was possible and could benefit them.

7.5 Crisis Management

One additional implementation approach that is worth noting is how policymakers and reformers in Kyrgyzstan dealt with crises that emerged as part of the health reform process. During implementation, health reform efforts faced a number of crises during implementation. How the MOH and donor organizations working in health reform responded to these crises greatly contributed

to the progress of reforms at pilot and national levels. Policymakers and implementers used crises as opportunities to solidify their health reform vision and approach. Crises and catalytic events impacting the health sector were managed by decision-making bodies that discussed alternatives, weighed options, and made informed decisions keeping the over-arching vision of the Issyk-Kul oblast health reform model and the MANAS Program in mind. Two examples of managing a crisis to reaffirm the health reform vision are the crisis surrounding the role of health insurance in early 1997 and the government's dissolution of oblast-level health departments in 2000.

Health insurance was proposed as part of the World Bank project design in 1996, raising the possibility that a new health insurance fund in the Kyrgyz health system would create a second health purchaser in addition to the MOH. Implementation of the World Bank loan was stopped to resolve this issue. Experience in Russia and Kazakhstan had shown many disadvantages of having two health purchasers: health policy was not coordinated, functions were duplicated, administrative costs increased, restructuring the health sector was difficult, contradictory financial incentives were created, the population was confused by two benefits packages, providers were incapable of managing payment from two sources, and fraud and abuse increased. In response to these concerns, health sector policymakers developed a new concept, approved by the government in mid-1997, called the Coordinated Policy for the Implementation of Health Reform and Health Insurance. This policy introduced five MOH and MHIF Jointly Used Systems – information, provider payment, accounting, quality assurance, and benefits coordination – to enable the MOH and MHIF to function as a single payer while remaining separate institutions with separate sources of financing. The Jointly Used Systems approach served as an effective precursor to introduction of a true single payer once the MHIF was moved under the authority of the MOH in 1999. It also reaffirmed the reform vision – a single payer with unified systems – and effectively turned crisis into consensus.

In 1999/2000, as part of broad government decentralization and downsizing, the government of Kyrgyzstan eliminated the oblast health departments (as well as oblast departments in other sectors). The MOH still relied on the oblast health department to finance and manage health facilities, and the decision had significant ramifications for the health sector. Dr. Meimanaliev, the Minister of Health at the time, responded by using the crisis as an opportunity to affirm the role of the oblast MHIF in pooling funds at the oblast level and paying health providers (setting the stage for the single-payer system) and to consolidate and rationalize the oblast hospital sector. The MOH-formed oblast merged hospitals and placed the former heads of the oblast health departments in charge of them, allowing them to keep a certain power balance with the oblast-level MHIF. The result was a reorganization of the roles of the oblast-level health sector that was acceptable to everyone, affirmation of the concepts of oblast pooling and the single-payer system, and consolidation of hospital care under a single administrative structure that would allow for further internal rationalization and consolidation in response to provider payment incentives. The MOH effectively used a political decision they may not have supported as an opportunity to contribute to meeting their health reform goals.

7.6 Counterparts and Donors

Counterpart institutions and donor organizations contributed to the success of the Issyk-Kul oblast pilot, as did dedicated individuals from these entities. The eventual roll-out of the Issyk-Kul health reform model was facilitated by donor collaboration mechanisms established to design the pilot intervention and the national reform plan, as well as active and continuous interaction between oblast- and national-level stakeholders. The MANAS Program provided an umbrella framework to guide and monitor MOH, MHIF, and donor activities at pilot and national levels. The MOH viewed many donor interventions after development of MANAS as pilot tests of aspects of the government reform plan. Coordination of donor activities was a crucial part of pilot site interventions and national health sector

planning beginning in 1994. Technical assistance from USAID, Swiss Red Cross, and other donors was effectively paired with World Bank and Asian Development Bank loans, as well as donor grants for reconstruction, equipment, medical supplies, drugs, and computers for maximum impact. WHO contributed significantly to developing the MANAS Program, providing technical assistance on content, setting up an effective policy development process, building capacity at the national and oblast levels, and evaluating the effects of health reform. Key counterparts were consistent and knowledgeable, and clearly were vested in developing a realistic health reform vision and ensuring its implementation. Health reform champions were gradually institutionalized in the MOH and MHIF, further increasing the sustainability of reform efforts. Key individuals from donor organizations also remained consistent and supportive, having been involved in early planning and implementation and just as eager as local counterparts for reforms to succeed.

Health reformers and other stakeholders in Kyrgyzstan have embraced the notion of piloting. Demonstrations are effective change agents in the former Soviet Union, overcoming many of the psychological and cultural obstacles hampering change. The nature of the still prevalent Soviet mentality requires visible successes to overcome skepticism; data and evidence to counter overly politicized central decision-making processes; incremental or step-by-step approaches to forestall the tendency to implement new programs too quickly; small victories to enhance the status of progressive health reformers; and learning by doing to improve problem-solving skills and encourage risk-taking behavior (Borowitz et al., 1999c).

7.7 Financing

The pilot in Issyk-Kul oblast and health reforms in Kyrgyzstan benefited from financing from donors, loans, and the local budget – without these committed resources, health reform efforts would not have been successful. Adequate financing ensured that the national health reform strategy was not just another unfunded or underfunded mandate, and that the initial pilot site could be rolled out nationwide. WHO helped finance the development of the MANAS Program. USAID helped finance development of the Issyk-Kul oblast pilot. With both of these initiatives well developed by 1996, it was perfectly natural that two World Bank loans (\$18M and \$15M), an Asian Development Bank loan (\$21M in South Kyrgyzstan), and subsequent donor assistance in the health sector would continue to support their development, implementation, evaluation, refinement, expansion, and institutionalization. Despite the Asian and Russian financial crises in the mid-1990s, the Kyrgyz government has remained committed to continuing to finance the health sector as it can. However, the MHIF has not received timely transfers from the Social Fund, and savings from rationalization within the health sector were not being reinvested in the health sector. Efforts are currently being made to make health financing more sustainable – ensuring timely transfers from the Social Fund by making them conditionalities of structural adjustment credits and drafting legislation on reinvestment of health sector savings (replacing an existing ineffectual Cabinet of Ministers decree). Recent piloting of the single-payer system – including significant restructuring of the service delivery system and the introduction of patient co-payments – already has provided revenue and cost savings that can be used to finance salaries, drugs, and supplies.

8. Conclusions

Despite the absence of a rigorous comprehensive evaluation, the health reform pilot in Issyk-Kul oblast can be considered a success. It was rolled out nationally and informed national level health reforms. While each of the factors described above is important in itself, perhaps the greatest achievement of the health reforms in Kyrgyzstan was the creation of a dynamic interaction and iteration among the factors, coordinated by health champions and donors guided by a unified health reform vision. A mechanism that enabled sustainable health system improvements at the facility, oblast, and national levels was the end result of the pilot rather than the effectiveness of the pilot itself or its successful roll-out.

Creating a dynamic for system- and facility-level change happened in three stages. The first stage was the initial pilot process that developed the internal workings or “engine” of the health reform process and addressed the technical issues at the core of the system – health delivery system restructuring, population involvement, provider payment systems, and health information systems. This process was started in Issyk-Kul oblast but was later rolled out to Bishkek and Chui oblast, then to South Kyrgyzstan, and then nationwide.

The second stage united these technical components under a unifying vision (the single-payer system) and repackaged the system to respond to consumers and patients (the benefits package) – adding a “chassis” to the health reform engine. The system-level reforms also created the autonomy and “space” needed to move forward with facility-level quality improvements. In the first stage, many attempts at facility improvements had proved unsuccessful or unsustainable due to system-level barriers and obstacles to implementation and regulation. The single-payer system was piloted in Issyk-Kul and Chui oblasts, then rolled out each year in two oblasts at a time.

Kyrgyzstan recently entered a third stage in the health reform process where a dynamic for sustainable change has been created – opportunities for both system-level and facility-level improvements exist. The MOH continues to design, implement, and evaluate pilot health reform interventions in Issyk-Kul oblast (and other oblasts), and immediately connects these efforts to national health reforms. Simultaneously, implementation of facility-level interventions continues to reveal problems with medical practices and standards, medical education, and public health that only the health system can address. The development of an effective dynamic process and experienced health reformers that allow and encourage sustainable health system improvements at both facility and system levels is the best legacy of the Issyk-Kul oblast pilot, and may be the true measure of its success.

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